

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-000739

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 393

Primary Registration District No. 1022

Registrar's No. 235

STATE FILE NUMBER

AMENDED

FILED JAN 25 1962

1. PLACE OF DEATH a. COUNTY <u>Clay</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Clay</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City North</u>		c. CITY OR TOWN <u>Kansas City North</u>	
Length of stay in 1b <u>27 yrs.</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>3536 No. Bales</u>		d. STREET ADDRESS (If outside, give location) <u>3536 No. Bales</u>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Granville F. Canaday</u>		4. DATE OF DEATH Month <u>January</u> Day <u>15</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9-9-1900</u>
9. AGE (last birthday) <u>61</u>		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mt. Credit Union</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>United Co-op Albany Mo.</u>	
11. BIRTHPLACE (City and state or country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Edward Canaday</u>		13b. MOTHER'S MAIDEN NAME <u>Lucinda Summa</u>	
14. NAME OF HUSBAND OR WIFE <u>Dorothy Canaday</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>[REDACTED]</u>		17. INFORMANT <u>Dorothy Canaday-3536 N. Bales</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the lung</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 mo</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female: was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year _____		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>Feb 1954</u> to <u>Jan 1962</u> and last saw him alive on <u>1-14-62</u>		Death occurred at <u>3:30 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <u>Robert H. Hodge M.D.</u>		22b. ADDRESS <u>320 Arman north Kansas City Mo</u>	
22c. DATE SIGNED <u>1/15/62</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>1-17-1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>White Chapel</u>	
23d. LOCATION (City, town, or county) (State) <u>Stadstone, Missouri</u>			
24. FUNERAL DIRECTOR <u>D.W. Newcomer's Son-North Kansas City 16, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>1-15-62</u>	
26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF Robert H. Hodge

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

John H. Kalsbeek

Licensed Embalmer No.

4949

P. O. Address

No Kansas

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.